MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

05969

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Cecil

City or town: Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs - 22 days

Hospital, Institution, or street address where death occurred: US Naval Hospital Naval Training Center, Bainbridge, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Dist. Columbia County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 198 "F" Street, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II

3.(a) FULL NAME

Roland Price ADKINS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Charlotte Riedel ADKINS

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 11, 1908.

8. AGE: Years	Months	Days	If less than one day
37	1	13	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US NavHospital, NTC Bainbridge, Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 26, 1945 (month) (day) (year)

Cemetery or crematory

Location: To Washington, D.C.

18. Funeral director: Lee A Patterson & Son
Address: Perryville, Md.

19. 6/26/45 (Date rec'd by registrar) Irene E. Donnelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 June 1945 at 2345 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 June 1945 to 24 June 1945 and that I last saw h[illegible] alive on 24 June 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions Acute toxic myocarditis & [illegible]	

(Include pregnancy within 8 months of death)

Major findings of operations: none

Date of op.

Autopsy results: Bronchopneumonia - Toxic myocarditis & [illegible]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. H. Burdick Cdr. MC USNR M. D. or other

Address: USN Hospital Bainbridge, Md. Date signed: 25 June 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

05970

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 116 Stockton
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John Cror Boulden

3.(b) Social Security Number 716-01-9284

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Lula Boulden
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): April 15 1880

8. AGE: Years	Months	Days	If less than one day
65	1	19	hrs. ... min.

9. Birthplace: Cecil Co Md. (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business:

FATHER
12. Name: Walter Boulden
13. Birthplace: Unknown

MOTHER
14. Maiden name: Isabel Cror
15. Birthplace: Woodstown Md

16. Informant: Lula Boulden
Address: 116 Stockton St Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1945 (month) (day) (year)
Cemetery or crematory: North East M E Cemetery
Location: North East Maryland
18. Funeral director: H W Pippin
Address: Elkton Md

19. June 7 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1945, at 3:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. L. Dodson MD Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md Date signed 6-4-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

05971

Reg. Dist. No. 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.

County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine C Broadbent

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1851

8. AGE: Years 94 | Months ~~5~~ | Days 13 | If less than one day hrs. min.

9. Birthplace Phila., Pa. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Samuel Broadbent

13. Birthplace England

MOTHER 14. Maiden name unknown

15. Birthplace

16. Informant Bertha A Smith

Address North East Md.

17. Burial (Burial, cremation, or removal—which?) Date thereof June 19 1945 (month) (day) (year)

Cemetery or crematory St Mary

Location North East Md.

18. Funeral director C. E. Tyson

Address Rising Sun Md.

19. June 18 1945 (Date rec'd by registrar)

Registrar

Permit issued 6-18-45

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 5A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to June 16 1945

and that I last saw h[illegible] alive on June 15 1945

Immediate cause of death	DURATION
Hemiplegia	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C E Dodson MD M. D. or other

Address Rising Sun Md. Date signed 6/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05972

Reg. Diat. No. 91

1. PLACE OF DEATH:

County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha J. Craig

3.(b) Social Security Number: none

4. Sex	5. Color or race	6. If single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: William H. Craig

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): July 6 1870

8. AGE:

Years	Months	Days	If less than one day
74	11	13	hrs. min.

9. Birthplace: Charleston Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: George Shelton

13. Birthplace: Md.

MOTHER 14. Maiden name: Lizzie J. Murphy

15. Birthplace: Md.

16. Informant: William H. Craig

Address: Chesapeake City

17. Burial (Burial, cremation, or removal — which?) Date thereof June 16 1945 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: near Chesapeake City

18. Funeral director: Edward Fellows

Address: Millington Md.

19. June 14th 1945 (Date rec'd by registrar) Iona Ruth O'Neill (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1945, at 12 20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to June 13 1945, and that I last saw h alive on June 13 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 year
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. J. Downs M.D. M. D. or other

Address: Chesapeake, Md. Date signed 6/13/45

(M) (1) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

05973

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo. 17 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Tucker

City or town: Parsons
(If outside city or town limits, write RURAL and give nearest town)

Street No. 219 Second Street
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American ✓

3.(a) FULL NAME: DUDLEY, William L.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): December 13, 1873

8. AGE: Years 71 | Months 6 | Days 17 | If less than one day: - hrs. - min.

9. Birthplace: Williamsport, Pa.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER
12. Name: Washington Lamuel Dudley
13. Birthplace: Elmira, N.Y.

MOTHER
14. Maiden name: Clara Carter
15. Birthplace: Lycoming County, Pa.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 1, 1945 (month) (day) (year)

Cemetery or crematory: City Cemetery

Location: Parsons, W. Va.

18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. July 1 1945 (Date rec'd by registrar) Irene E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945, at 8:52A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1945, to June 30 1945 and that I last saw him alive on June 30 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	18 hrs.
Due to: Cerebral arteriosclerosis	Over 1 yr.
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	over 4 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER Lt. Col., M.C. M.D. or other
Clinical Director
Address: Veterans Administration, Perry Point, Md. Date signed: 7-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05974

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mo. 27 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1476 Clifton St., N.W., Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I ✓

3. (a) FULL NAME: EASON, William V.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eunice Murphrey

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): May 23, 1893

8. AGE: Years	Months	Days	If less than one day
52	XX	25	- hrs. - min.

9. Birthplace: Johnson Co., N.C.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: -

FATHER
12. Name: Elishie Eason
13. Birthplace: Johnston Co., N.C.

MOTHER
14. Maiden name: Nancy Barnes
15. Birthplace: -

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 18, 1945 (month) (day) (year)

Cemetery or crematory: White Oak Cemetery

Location: Archer Lodge, N.C.

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grace, Md.

19. June 18 19 45 Irma E. Hughes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 19 45 at 3:11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1944, to June 17 1945 and that I last saw h... im ...alive on June 17 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	3 days
Due to: Cerebral Arteriosclerosis	Over 1 yr.
with hemiplegia, left	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: J. E. Trollinger
M.D. or other
Address: J. E. TROLLINGER, Lt. Col. M.C. Clinical Director Veterans Administration, Perry Point, Md.
Date signed: 6-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bo-a)

CERTIFICATE OF DEATH

05975

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CECIL

City or town: Bainbridge, Maryland/ (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo - 18 days

Hospital, Institution, or street address where death occurred: US Naval Hospital Naval Training Center, Bainbridge, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: VIRGINIA County: Alleghany

City or town: Covington (If outside city or town limits, write RURAL and give nearest town)

Street No. 325 Stewart Street (If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II ✓

3.(a) FULL NAME: Ernest Clayton G R A N T, Jr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Not married

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 27, 1927

8. AGE:	Years	Months	Days	If less than one day
	17	8	18	....hrs. ....min.

9. Birthplace: Amherst County, Virginia (Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business: —

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: US NavHospital, NTC Bainbridge, Md.

Address: Bainbridge, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Covington, Va.

18. Funeral director: L. E. A. Patterson & Son

Address: Berryville, Md.

19. June 16 1945 Irma E. Dunford (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 June, 1945 19.... at 1:12A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13, June 19 45 to 15 June 19 45 and that I last saw h... alive on 14 June 1945 19....

Immediate cause of death	DURATION
Abscess, subdural	
Due to: Upper respiratory infection	
Due to:	
Other conditions: Status epilepticus	
Left frontal lobectomy (Include pregnancy within 3 months of death)	

Major findings of operations: Subdural abscess, left frontal. Date of op. 13, June 1945

Autopsy results: Bore out operative findings

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. L. Gaye Lt. Cmd MC USNR. M. D. or other

Address: Bainbridge, Md. Date signed 15 June 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

05976

Reg. Dist. No. 92

1. PLACE OF DEATH

County: Cecil

City or town: Elkton RD 4

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD 4

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Katie Fredrika Johnson.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed.

6.(b) Name of husband or wife: Oscar Johnson.

(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 26, 1884

8. AGE: Years 61 | Months 3 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Finland

(Town, county, and state)

10. Usual occupation: housekeeper

11. Industry or business

FATHER

12. Name: unknown.

13. Birthplace: Finland

MOTHER

14. Maiden name: unknown.

15. Birthplace: Finland.

16. Informant: Oliver Johnson.

Address: Elkton RD 4 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 24, 1945 (month) (day) (year)

Cemetery or crematory: North East Methodist

Location: North East, Md.

18. Funeral director: N. W. Lapsley

Address: Elkton, Md.

19. June 23 1945 (Date rec'd by registrar) H R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. Dodson M.D. Medical Examiner Co. Cecil County

Address: Rising Sun Md. Date signed: 6/22/45

M. D. or other

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05977

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil
City or town: Conowingo, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 67 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Conowingo, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Philena E. Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married.

6.(b) Name of husband or wife: Richard Jones.
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.): April 24, 1878

8. AGE: Years	Months	Days	If less than one day
67	2	6	hrs. min.

9. Birthplace: Conowingo, Md. (Town, county, and state)
10. Usual occupation: Housemaid
11. Industry or business

FATHER
12. Name: Lewis Peters
13. Birthplace: Md.

MOTHER
14. Maiden name: Isabelle Johnson
15. Birthplace: Md.

16. Informant: Richard Jones
Address: Conowingo, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 1945 (month) (day) (year)
Cemetery or crematory: Mt Olivet Md.
Location: Conowingo Md.

18. Funeral director: J. C. Tyson
Address: Rising Sun, Md.

19. July 2 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1945 to June 28 1945 and that I last saw h[illegible] alive on June 28 1945.

Immediate cause of death: Cerebral Hemorrhage — Paralysis Left Side. — DURATION: 5 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

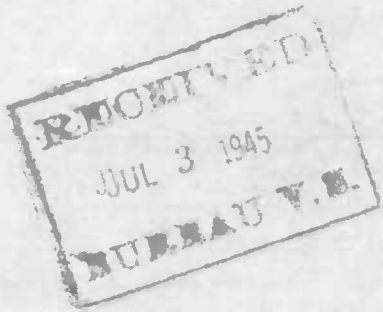
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

29. SIGNATURE: E. F. Johnson, M. D.
M. D. or other
Address: Port Deposit, Md. Date signed 7-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUL 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05978 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred: Union Hospital
Hospital May 30 to June 5. 1945
How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sarah Malin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Harry Malin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby 22 1870

8. AGE: Years: 75 | Months: 3 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Marshallton Delawan
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Foraker
13. Birthplace: Delawan

MOTHER
14. Maiden name: Sarah Dagny
15. Birthplace: Delawan

16. Informant: Harry Malin
Address: Elkton. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7 1945 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Elkton R D

18. Funeral director: H. W. Pippin
Address: Elkton Md

19. June 7 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1945 at 7 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1944 to June 5 1945
and that I last saw h... alive on June 4 1945

	DURATION
Immediate cause of death: Bronchopneumonia	June 3, 1945
Due to: Cerebral accident	October 1944
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clifford N. Strahan M.D.
M. D. or other
Address: Elkton, Md. Date signed June 6 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Diat. No. 05979 96

1. PLACE OF DEATH:

County CECIL

City or town VETERANS ADMINISTRATION, Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yr. 5 mo. 4 da.

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore ~~Harford~~

City or town Joppa

(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2.(a) If veteran, name war W.W. I ✓

3. (a) FULL NAME: MARHENKE, Carl B.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	28	- hrs. - min.

8. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Bookkeeper

11. Industry or business: -

FATHER — 12. Name: August H. Marhenke, retire

13. Birthplace: GERMANY

MOTHER — 14. Maiden name: Annie Bergen

15. Birthplace: MARYLAND

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal, Which?) Date thereof June 22, 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Locatico: Woodlawn, Md.

18. Funeral director: Pennington & Son

Address: Pennington & Son, Havre de Grace, Md.

19. June 22 19 45 (Date rec'd by registrar) Irene E. Dunfee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 19 45, at 8:40A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 18 1939 to June 22 19 45

and that I last saw him alive on June 22 19 45

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic far advanced	0 yer 7 yrs.
Due to:	
Due to:	
Other conditions: Dementia Precox, Hebephrenic type	25 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op. -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE: A. E. TROLLINGER, Lt. Col., M.C., Clinical Director

Address: Veterans Administration, Perry Point, Md. Date signed: 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

05980

Reg. Dist. No. 96

1. PLACE OF DEATH
County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurrad:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie Elizabeth McCullough

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

B.(b) Name of husband or wife James P. McCullough
6.(c) If alive, give age years

7. Birth date of dacaased (mo., day, yr.) Dec. 5, 1869

8. AGE:

Years	Months	Days	If less than one day
75	6	19	hrs. min.

9. Birthplace Principio Furnace, Cecil, Md
(Town, county, and state)
10. Usual occupation Home Wife
11. Industry or business
FATHER 12. Name William F. Owens
13. Birthplace Cecil Co. Md.
MOTHER 14. Maiden name Annie E. Baker
15. Birthplace Cecil Co. Md.
16. Informant Ruth E. Stephenson
Address Perryville, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27, 45 (month) (day) (year)
Cematary or crematory Principio
Location Principio Furnace, Md.
18. Funeral director Lee A. Patterson & Son
Address Perryville, Md.
19. June 27 1945 Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945 at 2:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to June 24 1945 and that I last saw h... alive on June 20 1945

	DURATION
Immediate cause of death Acute Dilation of Heart	Immediate
Due to Chronic Endocarditis	Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other
Address Perryville Md Date signed 6/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

#5981 Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~5 Yrs~~ Life

Hospital, institution, or street address where death occurred: Union Hospital - Elkton - Md

How long in hospital or institution? 7 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East - Md R.D. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Mary McKinney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John Henry McKinney

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1936 1876

8. AGE: Years 69 | Months 1 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cecil Co - Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John F. Dean

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Debra Lynch

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs Fredrica Jensen-daughter

Address: Elkton - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 15 1945 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R. Grant

Address: North East

19. June 12 1945 (Date rec'd by registrar) F.K. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945 at 10.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 1945 to June 11 1945 and that I last saw her alive on June 11 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	5 days plus
Due to:	
Due to:	
Other conditions: Diabetis Mellitus	6 yrs plus

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: T. H. McKnight M. D. or other

Address: Elkton - Md Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

T 05982

Reg. Diat. No. 92

1. PLACE OF DEATH: Cecil
County
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, Institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Phylis Louise Moore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 11 1945

8. AGE: Years	Months	Days	If less than one day
0	3	29	hrs. min.

9. Birthplace Elkton Cecil Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Louis A. Moore
13. Birthplace New Brunswick N J

MOTHER
14. Maiden name Esther May Fowble
15. Birthplace Elkton Md

16. Informant Louis A Moore
Address Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17 1945 (month) (day) (year)
Cemetery or crematory Elkton cemetery
Location Elkton Md

18. Funeral director H. W. Lippincott
Address Elkton Md

19. June 11 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

30

20. DATE OF DEATH June 9th 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15th 1945 to June 9 1945
and that I last saw h... alive on June 2 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	7
Due to W Whooping Cough	10 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Date signed June 11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

65983

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:
County North East Cecil Co Md
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town North East
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war Not a Veteran

3.(a) FULL NAME Isaac B Neal

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W White	M widowed

6.(b) Name of husband or wife Martha C Neal
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 30 1851

8. AGE: Years 93 | Months 11 | Days 20 | If less than one day ... hrs. ... min.

9. Birthplace Pleasant Garden, Chester Co. Pa.
(Town, county, and state)

10. Usual occupation Farm manager

11. Industry or business —

FATHER
12. Name William B Neal
13. Birthplace Penna

MOTHER
14. Maiden name Elizabeth Ann Boulden
15. Birthplace Cecil Co. Md

16. Informant Mrs Geo Phu Craig
Address North East. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23-1945 (month) (day) (year)
Cemetery or crematory Methodist
Location North East Md

18. Funeral director Joseph R Grant
Address North East Md

19. 6/26 1945 Lida E. Owens
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 16 1945 to June 20 1945 and that I last saw him alive on June 19 1945

Immediate cause of death	DURATION
Myocarditis	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE C. B. Collins M. D. or other
Address North East, Md. Date signed 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM A...G 96 JUN 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05984

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs. 5 mo. 25 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Liberty Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No. -
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME: PIERCE, Russell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): October 1, 1889

8. AGE: Years	Months	Days	If less than one day
55 51	2- 8	27 20	- hrs. - min.

9. Birthplace: Rising Sun, Md.
(Town, county, and state)

10. Usual occupation: Laborer-farm

11. Industry or business: -

FATHER
12. Name: Grant Pierce
13. Birthplace: Unknown

MOTHER
14. Maiden name: Martha Bromel
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 6-25-45 (month) (day) (year)
Cemetery or crematory: Freemont Cemetery
Location: Freemont, Pa.

18. Funeral director: Cunningham & Son
Address: Havre de Grace, Md.

19. June 25 19 45 (Date rec'd by registrar) June E. Dempsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 19 45 at 2:05P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27, 1929 19 to June 21 19 45
and that I last saw him alive on June 21 19 45

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic, far advanced, active	6 mo.
Due to:	
Due to:	
Other conditions: Dementia Precox, Hebephranic type	18 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op. -
Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): -
Means of injury - Injured at work? -

23. SIGNATURE: A. E. Trollinger M.D.
Address: Veterans Administration, Perry Point, Md.
A. E. TROLLINGER, Lt.Col., M.C. Clinical Director
Date signed: 6-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05985

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred: Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 328 S. Oldham Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: PIEREMAN, Henry B.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowerer

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 9-8-1886

8. AGE: Years	Months	Days	If less than one day
58	9	6	- hrs. - min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual occupation: Hospital orderly

11. Industry or business: -

FATHER

12. Name: George E. Piereman

13. Birthplace: West Virginia

MOTHER

14. Maiden name: Johanna E. Wright

15. Birthplace: Richmond, Va.

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 6-15-1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

16. Funeral director: Pennington & Son, Havre de Grace, Md.

Address

19. June 15 1945 Irene E. Daugherty Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 1945, at 6:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1945 to June 14 1945

and that I last saw him alive on June 14 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 da.
Due to:	
(a) Arteriosclerosis, general, cerebral & coronary	Unknown
Other conditions: Psychosis with cerebral arteriosclerosis	Unknown
(Include pregnancy within 3 months of death) Cerebral Thrombosis	Unknown

Major findings of operations: -

Date of op.: -

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. TROLLINGER, Lt. Col. M.C. Clinical Director (M. D. or other)

Address: Veterans Administration, Perry Point, Md. Date signed: 6-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

05986

Reg. Dist. No. 95

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1

A

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Outside Rising Sun.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Outside Rising Sun.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Albert A. Reynolds

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	11	..... hrs. ..... min.

9. Birthplace: North East Cecil Co. Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Levin Reynolds

FATHER 13. Birthplace: Rising Sun. Md.

MOTHER 14. Maiden name: Margaret Reynolds

MOTHER 15. Birthplace: Rowlandville.

16. Informant: Mae Euler

Address: Rising Sun. Md. R. F. D.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 17, 1945 (month) (day) (year)

Cemetery or crematory: Fremont, Pa.

Location: Fremont, Pa.

18. Funeral director: J. E. Tyson.

Address: Rising Sun Md.

19. 6/16/45 (Date rec'd by registrar) L. M. Worthington Registrar

Permit issued 6-16-45

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945 at 8 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 16 1945

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemiplegia	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. M. D. or other

Address Rising Sun Md. Date signed 6/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

05987

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton - Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, Institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 3 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Elkton - Md County: Cecil

City or town: RD. 5

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Florence Rule

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Unknown deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 29. 1854

8. AGE: Years: 91 | Months: 3 | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Farm Worker and Housework

11. Industry or business: Farming

FATHER

12. Name: Joseph ? (unknown)

13. Birthplace: Unknown

MOTHER

14. Maiden name: Ellie ? (unknown)

15. Birthplace: Unknown

16. Informant: deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23/45 (month) (day) (year)

Cemetery or crematory: Cherry Hill County Cemt

Location: Cherry Hill Md

18. Funeral director: H. W. Lapsley

Address: Elkton, Md

19. June 23 1945 (Date rec'd by registrar) F. K. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17- 1945, at 6.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 th 1945, to June 17- 1945 and that I last saw her alive on June 16-1945 1945

Immediate cause of death	DURATION
Cancer of Liver	6 mos. ?
Due to	
Due to	
Other conditions: General Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: V. H. McKelvey Dr. M. D. or other

Address: Elkton - Md Date signed 6/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

CERTIFICATE OF DEATH

05990

Reg. Dist. No. 95

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING (M) (1)

1. PLACE OF DEATH:
County: Cecil
City or town: Rural - Colora
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Rural - Colora
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Frances Ewing Russell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): October 8, 1861

8. AGE: Years	Months	Days	If less than one day
83	8	13	hrs. min.

9. Birthplace: Colora, Cecil, Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Edward Thomas Russell
13. Birthplace: Bay View, Maryland

MOTHER
14. Maiden name: Miriam Huldah Clendenin
15. Birthplace: Colora, Maryland

16. Informant: Miriam E. Russell
Address: Colora, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24, 1945 (month) (day) (year)
Cemetery or crematory: West Nottingham
Location: Colora Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun Md.

19. 6/22/45 (Date rec'd by registrar) 19 E.W. Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 - 45, 19, at 12 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 19 45 to June 20 19 45
and that I last saw her alive on June 20 19 45

Immediate cause of death: Chronic Myocarditis — DURATION: 5 yrs
Due to: Chronic Endocarditis — 5 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. J. Benson M.D. M. D. or other
Address: Port Deposit Date signed: 6/22/45

05988

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occured:
Union Hospital
How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 128 Cathedral St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Scarborough

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Matthew T. Scarborough
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	3	4		

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: John Gregg
13. Birthplace: Maryland
MOTHER 14. Maiden name: no information
15. Birthplace: "
16. Informant: Joseph Scarborough
Address: Elkton, Maryland
17. ✓ (Burial, cremation, or removal. Which?) Date thereof 6/21/45 (month) (day) (year)
Cemetery or ~~crematory~~: Sharps
Location: near Fair Hill, Md.
18. Funeral director: Florence E Abernathy
Address: Elkton R.D. 5 Md
19. June 21 1945 F R Fraser
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945 at 6:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935, to June 19, 1945
and that I last saw h...alive on June 19, 1945

Immediate cause of death	DURATION
Diabetes Mellitus	
Due to	
Due to	
Other conditions: Chronic Interstitial Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herbert Bates M.D.
M. D. ~~or other~~
Address: Elkton, Md. Date signed: 6/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

05989

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months 10 days

Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCen Bainbridge, Maryland.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Texas County: Harris

City or town: Houston
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 1019 Gregg Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WORLD WAR II ✓

3.(a) FULL NAME

Israel S C O T T, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: Not married

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 16, 1926

8. AGE: Years	Months	Days	If less than one day
19	5	10	..... hrs. ..... min.

9. Birthplace: Houston, Harris City Texas
(Town, county, and state)

10. Usual occupation: US Navy

11. Industry or business

FATHER
12. Name: Israel SCOTT, Sr
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: US Naval Hospital, NavTraCen

Address: Bainbridge, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 27, 1945 (month) (day) (year)

Cemetery or crematory

Location: Houston, Texas

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. June 27 1945 Irene E Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945, at 0505 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 24 1945 to June 26 1945 and that I last saw h.. alive on June 26 1945

Immediate cause of death	DURATION
Meningitis: Acute Cerebrosp.	8 hours
Due to: Cerebrospinal fever, a meningococcic	
Due to: Meningococcus, Group I.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry S. Lewis Lt. Comdr MC USNR
M. D. or other

Address: U.S.N.H. Bainbridge Md. Date signed June 26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

05991

Reg. Dist. No. 95

1. PLACE OF DEATH:
County: Cecil Co. Md.
City or town: Near Rising Sun Md. R.F.D. 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil Co.
City or town: Near Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ralph John Shumate

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 7 1943

8. AGE: Years	Months	Days	If less than one day
2	1	15	hrs. min.

9. Birthplace: Street, Harford Co. Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name: George Shumate
13. Birthplace: N. C.
MOTHER 14. Maiden name: Effie Billings
15. Birthplace: Va.
16. Informant: George Shumate
Address: Rising Sun Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 (month) (day) (year)
Cemetery or crematory: Baptist Cem.
Location: Conowingo Md.
18. Funeral director: J. E. Tyson
Address: Rising Sun Md.
19. June 24 1945 L. W. Worthington Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1945 at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-14 1945 to 6/22 1945 and that I last saw h... alive on 6/21 1945

Immediate cause of death	DURATION
Rheumatic Fever	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Eldon Oden M.D.
M. D. or other
Address: Rising Sun Md. Date signed 6/22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

7

05992

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Logan

City or town: Edelton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allen Hospital

How long in hospital or institution? 3 minutes.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: Mingo

City or town: Williamson

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war — V

3.(a) FULL NAME Orna Soler.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband ~~or wife~~ Grover C. Soler

6.(c) If alive, give age About 58 years

7. Birth date of deceased (mo., day, yr.) Jan. 13 1895

8. AGE: Years	Months	Days	If less than one day
50	4	26	....hrs. ....min.

9. Birthplace Lenora, Mingo Co. West Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Dillon

13. Birthplace West Virginia

MOTHER 14. Maiden name Nick Newsom

15. Birthplace West Virginia

16. Informant Ella marie Croft

Address Elkton MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12, 1945 (month) (day) (year)

Cemetery or crematory North Evan Methodist

Location North Evan Md

18. Funeral director Joseph R. Grant

Address North East. Md.

19. June 11 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945, at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Coronary	
Due to, Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE R L Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address Perryville Md. Date signed 6-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

05993 Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Union Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town North East Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Randolph Webb

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1888

8. AGE:

Years	Months	Days	If less than one day
56	11	15	hrs. min.

9. Birthplace Orange Co Va
(Town, county, and state)
10. Usual occupation Farm Laborer
11. Industry or business
FATHER 12. Name Rutrang Overton Webb
13. Birthplace Orange Co. Va
MOTHER 14. Maiden name Mimbrina Allen Kempsey
15. Birthplace Orange Co Va
16. Informant Joseph R Grant
Address North East, Md
17. Removal Date thereof June 13-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Culpepper Va
18. Funeral director Joseph R Grant
Address North East, Md
19. June 12 1945 J R Grant
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUN 12 1945 at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to JUN 12 1945
and that I last saw h... alive on JUN 12 1945

Immediate cause of death	DURATION
Chronic myocarditis & chronic N. Nephritis	
Due to —	
Due to —	
Other conditions Incontinent Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jas F Husband M. D. or other
Address Elkton Date signed JUN 12 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

Reg. Dist. No. 59492

1. PLACE OF DEATH:
County: Cecil.
City or town: Elkton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, institution, or street address where death occurred: Union Hospital.
How long in hospital or institution? 2 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 228 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John Archibald Wolever. **3.(b) Social Security Number** 214-01-0397

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh	Married.

6.(b) Name of husband or wife: Edith Wolever. 6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1893

8. AGE: Years	Months	Days	If less than one day
51	8	5	hrs. min.

9. Birthplace: Williamsport Pa (Town, county, and state)
10. Usual occupation: Chemist.
11. Industry or business
FATHER 12. Name: Oscar Wolever
13. Birthplace: Williamsport, Pa
MOTHER 14. Maiden name: Jennie Muro
15. Birthplace: Pa.
16. Informant: Mrs. Edith Wolever
Address: 228 E Main St Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24, '45 (month) (day) (year)
Cemetery or crematory: Elkton.
Location: Elkton, Md
18. Funeral director: H. W. Peppin
Address: Elkton, Md.
19. June 23 1945 (Date rec'd by registrar) H R Teagen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945, at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930, to June 21 1945
and that I last saw him alive on June 21 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herbert Bale, M. D. (M. D. or other)
Address: Elkton Md Date signed: 6/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

05395

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mo. 5 da.
Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Fairfax
City or town: Falls Church
(If outside city or town limits, write RURAL and give nearest town)
Street No.: - -
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: WOODRING, Hurst J.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nancy Galt
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): December 15, 1897

8. AGE: Years	Months	Days	If less than one day
47	5	22	- hrs. - min.

9. Birthplace: Reading, Pa. (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: -

FATHER
12. Name: James Daniel Woodring
13. Birthplace: Allentown, Pa.

MOTHER
14. Maiden name: Margaret Hurst
15. Birthplace: Talmadge, Pa.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 7, 1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. June 7 1945 (Date rec'd by registrar) Registrar: Irma E. Daugherty

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1945, at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 1944 to June 6 1945 and that I last saw him alive on June 6 1945

Immediate cause of death	DURATION
Thrombosis, coronary	Indefinite
Nephritis, chronic	Undetermined
Due to:	
Due to:	
Other conditions: Psychosis Manic Depressive Depressed type	10 months
(Interval between onset and death) Nephritis, chronic	Unknown

Major findings of operation: -
Date of op.: -
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? - (City or town) - (County) - (State)
Injured at home, farm, industry, public place (where?): *
Means of injury: - Injured at work? -

23. SIGNATURE: H. E. Trollinger
H. E. TROLLINGER, Lt.Col. M.C. Clinical Director
Veterans Administration, PERRY POINT, MD.
Date signed: 6-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15